# Improving Health Care Quality and Cost State of Washington

January 2006



# Governor's Work Group on Health Care Quality and Cost—Project Scope

### A coordinated, statewide approach to corralling health care costs

- Reduce rate of health care cost growth for State government
- Reduce rate of health care cost growth for businesses in the State

### Look at everything possible that can:

- Improve quality
- Lower costs
- Increase access

#### Make specific recommendations that:

- Can be implemented under current law
- Call for legislation next session
- Can be advocated by the Governor—changes in the broader system and federal government

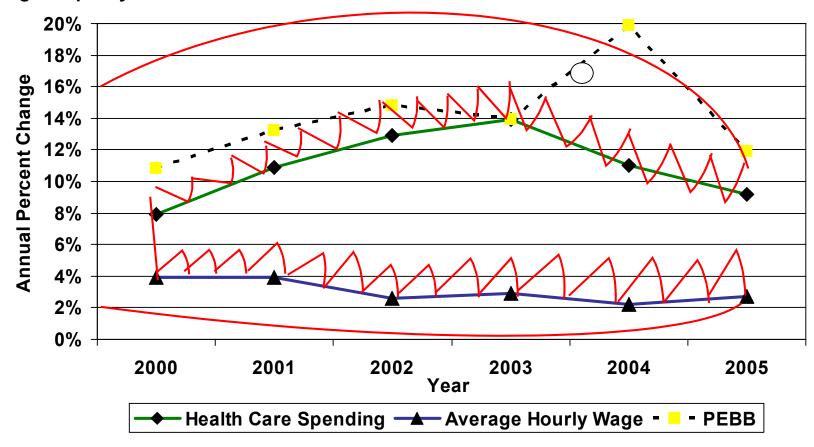
#### Charge:

- Do not cut the number of people covered by State programs
- Take risks
- Be innovative
- Develop public-private partnerships

### Meet the Shark

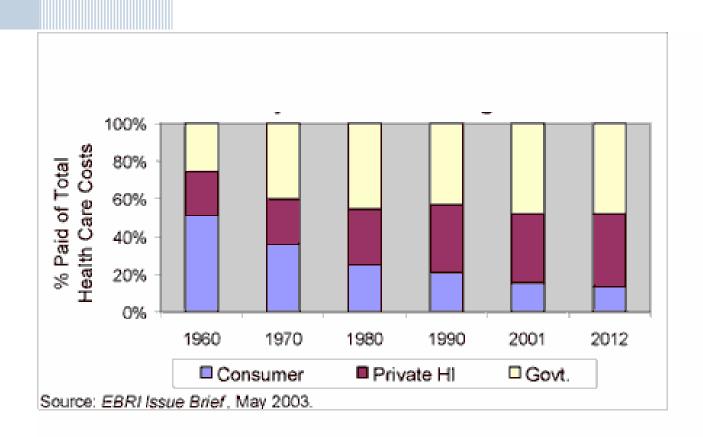
# Outswim It or Spend >50% of Employee and Retiree Income on Health Care

Annual Percent Changes per Capita in Health Care Expenditures and in Average Hourly Wages for Workers in All Industries, 2000 through 2005. Average annual incremental benefit = 44 days of good quality life.



Data from Kaiser Permanente/Health Research & Educational Trust 2005. Dental work by Dr. Milstein.

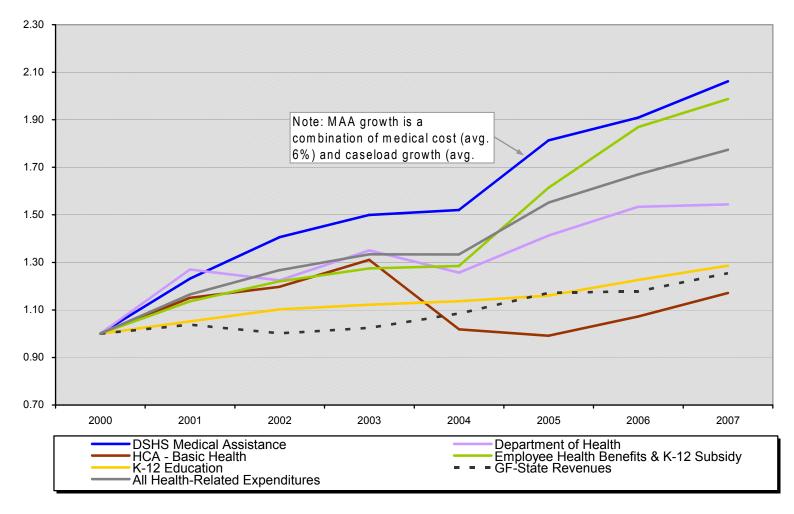
### **Employer and Government Share Is Increasing**



### Washington State Health Expenditures

dollars in millions • appropriated state funds • actuals FY00-FY04, budget FY05-FY07 \$2,500.0 \$2,000.0 \$1,500.0 \$1,000.0 \$500.0 \$0.0 FY00 FY01 FY02 FY03 FY04 FY05 FY06 FY07 ■ Long-Term & Institutional Care ■ DOC ■ DSHS Medical Assistance □ DSHS Behavioral Health ■ Department of Health HCA - Basic Health ■ HCA - Clinic grants, policy, WSHIP, etc. ■ K-12 Student Health Programs ■ Employee Health Benefits & K-12 Subsidy ■ L&I Health Expenditures

# **Growth in Selected Costs versus Growth in General Fund-State Revenue**



### **Large Employer Health Care Strategies**

#### Data Analysis and Diagnosis

Business and HR Priorities
Enrollment, costs and demographics
Cost drivers and savings opportunities

#### **Traditional Tactics**

#### Plan Design

- Types of plans
- Number of choices
- Cost Sharing
- Service-related offerings
- Pay-related designs
- Pharmacy
  - Savings/spending accounts

#### Financing

- Funding decision insured, self-insured, minimum premium
- Gain sharing
- Employee self-funding FSA, HRA

#### Contributions

- Percentage of cost
- Salary stratified
- Indexed to plan costs
- Tiered for family size
- Risk-related
- Opt-out credits (cash)

#### Vendors

- Vendor selection
- Performance measures
- Clinical capability
- Operational audits
- Network strategy
- Renewal negotiation

#### **Advanced Strategies**

### Maintain a healthy workforce

- Identification of health risks
- Health promotion programs
- Self-care assistance
- Health risk management
- Incentives for health awareness – risk appraisal participation

### Focus on high cost population

- Disease management
- Case management
- Maternity programs
- Advocacy programs
- Incentives for care management compliance
- Integrate information and/or care management with disability and worker's compensation

### Engage employees in behavior change

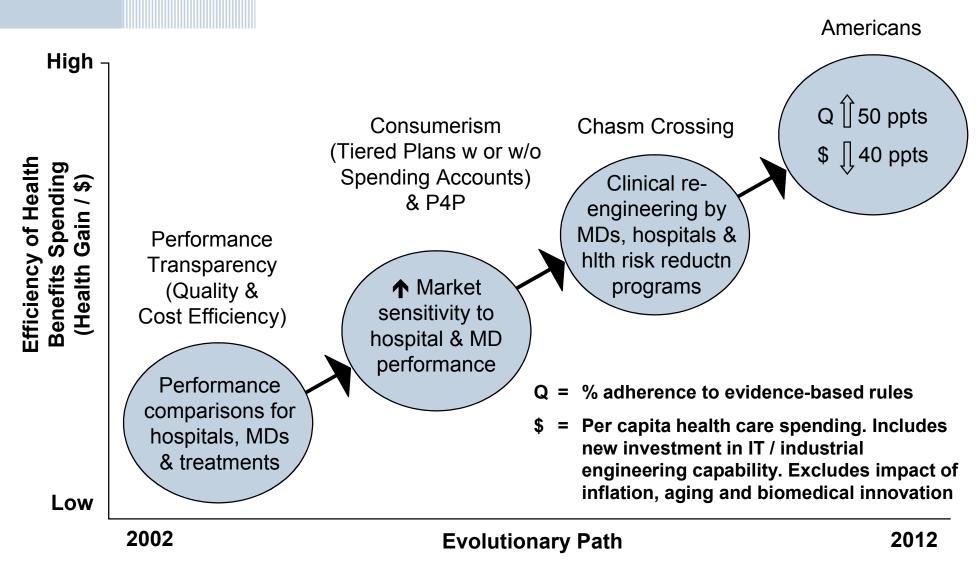
- Raise cost awareness through education and cost sharing
- Education about cost and health conditions
- Tools about provider cost and quality
- Availability of savings accounts

### Purchase Highest Quality and Most Cost Effective Care

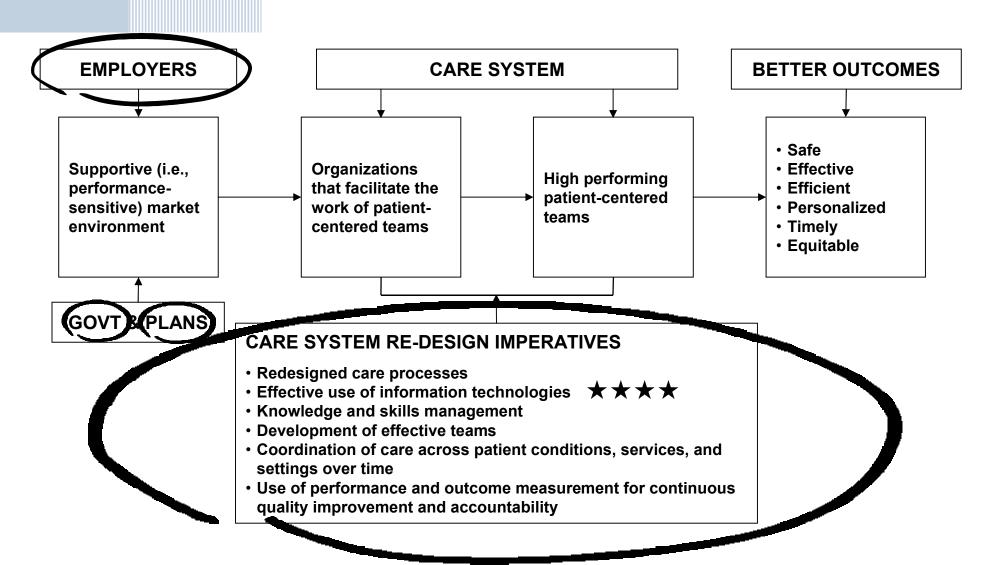
- High performance network
- Collective purchasing
- Supply chain purchasing
- National initiatives for quality improvement

Source: Mercer Human Resource Consulting

### A Near-Term Vision that Benefits All Stakeholders



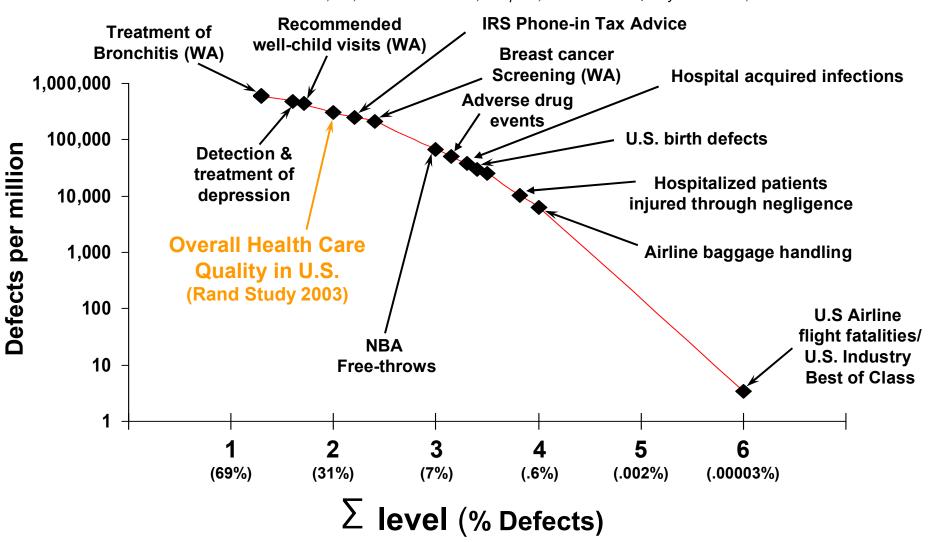
### A Similar Vision from the Institute of Medicine



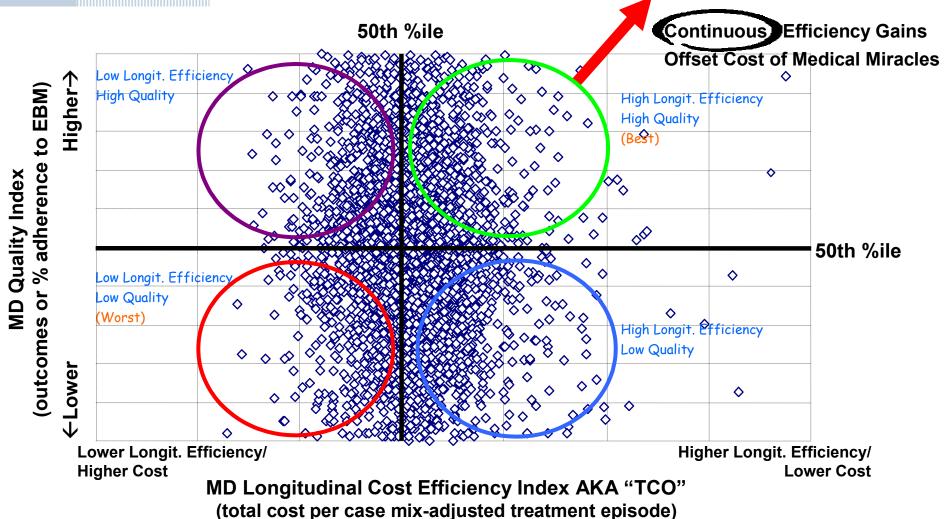
8

### Health Care Quality Defects Occur at Alarming Rates

Sources: modified from C. Buck, GE; Dr. Sam Nussbaum, Wellpoint; Premera 2004 Quality Score Card; March of Dimes



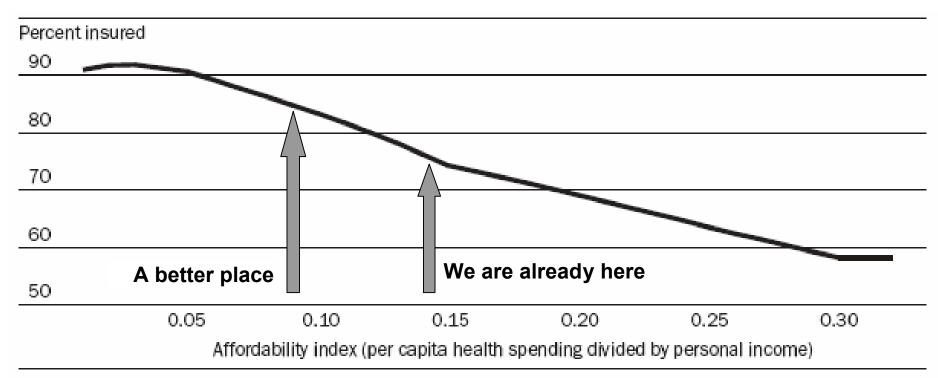
### Incentivizing Robust Re-Engineering of Health "Production" is the Only Infinite Method of Stabilizing Health Care Spending



# How Much Would a 40% Gain in the Efficiency of the Health Industry Reduce Uninsurance?

### Predicted Percentage Insured Among Workers, By Affordability Index

From "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," by Gilmer and Kronick, Health Affairs, April 2005



**SOURCES:** Authors' analysis of Current Population Survey (CPS), March supplements, Annual Demographics Files, 1980–2003, except 1981; and Centers for Medicare and Medicaid Services, National Health Accounts, 1979–2002.

### Governor's Work Group on Health Care Quality and Cost

#### **Initatives**

- 1. Centralized, collaborative, evidenced based set system to set priorities and determine what the State will pay for.
- 2. Effectively manage the 'High Opportunity' populations insured or sponsored by the State 5%-50% population
- 3. Promote the transparency of health plan and provider performance.
- 4. Prevention and Wellness for State Employees and Beneficiaries
- Encourage technology improvements in patient/provider information

#### **Others**

- Improve PEBB procurement to improve quality and cost.
- Medicaid Cost Containment
- Improve the insurance market for small employers and individuals
- Reduce the impact of State administrative impacts on providers
- Explore the creation of an Institute for Clinical Performance Improvement

### What's Wrong? Quality Performance Is Too Low

- RAND: Americans get evidence-based care only 55% of the time
- IOM: up to 98,000 Americans die each year due to avoidable medical errors
- NCQA: up to 79,000 Americans die each year due to quality gaps
- CDC: 2 million patients acquire infections in the hospital each year => 90,000 die

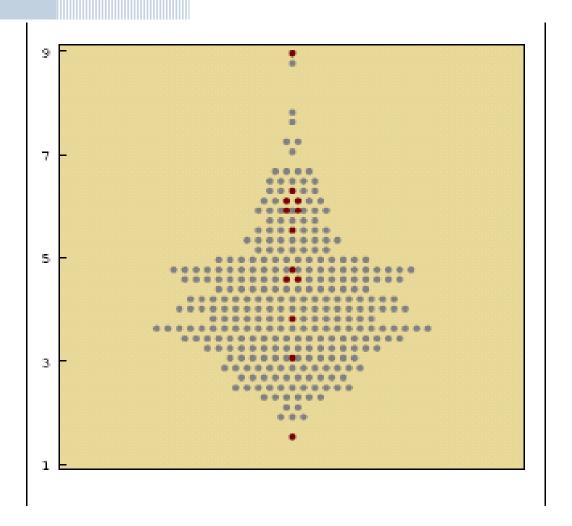
# **Preventing Complications and Premature Death**

# Patients get recommended care only half of the time; consequences are avoidable.

Condition	Shortfall in Care	Avoidable Toll
Diabetes	Average blood sugar not measured for 24%	2,600 blind; 29,000 kidney failure
Hypertension	< 65% received indicated care	68,000 deaths
Heart Attack	39% to 55% didn't receive needed medications	37,000 deaths
Pneumonia	36% of elderly didn't receive vaccine	10,000 deaths
Colorectal Cancer	62% not screened	9,600 deaths

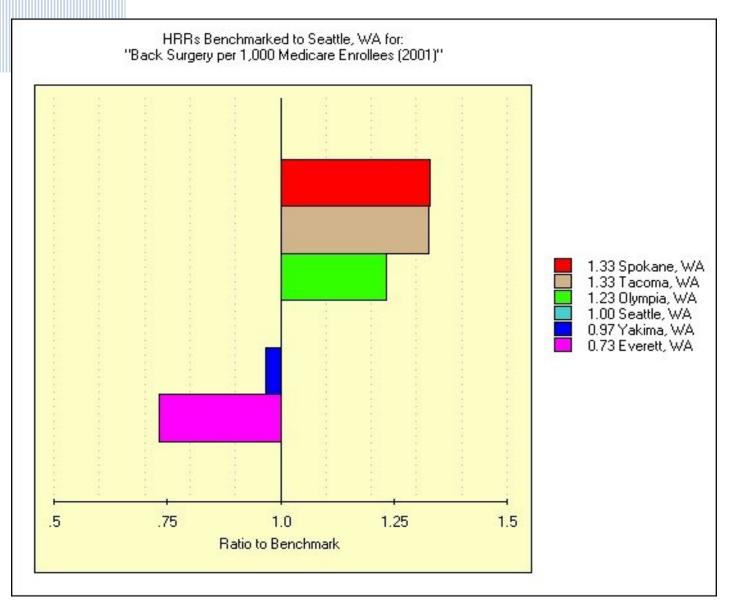
Source: Elizabeth McGlynn et al, RAND, 2004

### **Surgery for Back Pain**



Bend, OR	9.0
Eugene, OR	6.2
Portland, OR	6.1
Salem, OR	5.9
Spokane, WA	5.8
Medford, OR	5.8
Tacoma, WA	5.4
Yakima, WA	4.6
Seattle, WA	4.5
Olympia, WA	4.5
Everett, WA	3.8
Anchorage, AK	3.0
Honolulu, HI	1.3

### **Back Surgery**



# Sample Process Reengineering in Dr's Office An Initial "Rebuild" of an Ophthalmology Visit

Before

"we're doing everything we can think of... we need more money!"

Traditional model
1 assistant/MD
Staff poorly trained
2 rooms/MD



22 patients/day/MD
3 month wait for consult
Patient Satisfaction = 63%
Provider Satisfaction = 90%
\$60 per visit
\$22.31 per beneficiary/year

After

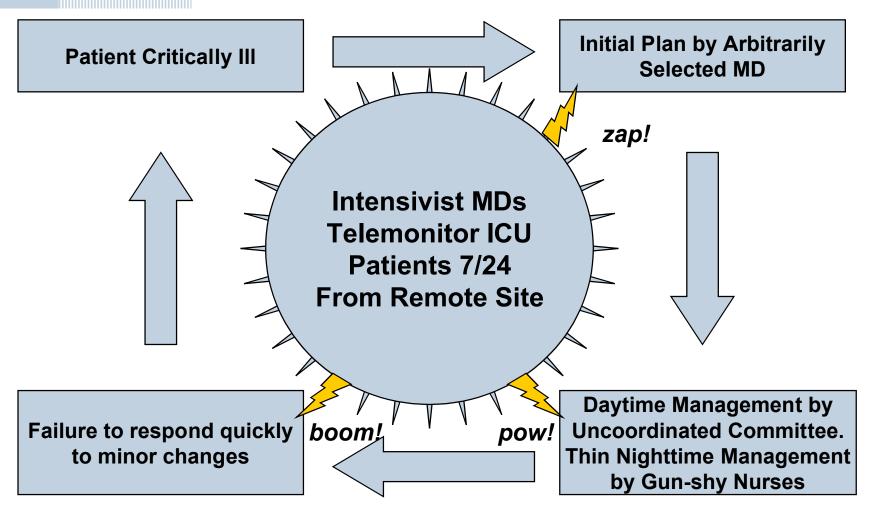
"we're doing what we didn't know about before... we need less money!"

Engineered model 3 assistants/MD Staff highly trained 4 rooms/MD



50 patients/day/MD
No wait for consult
Patient Satisfaction = 85%
Provider Satisfaction = 94%
\$43 per visit
\$14.91 per beneficiary/year

# Sample Process Reengineering in Hospital An Initial "Rebuild" of an ICU Stay



The Bottom Line: 54% reduction in mortality and 21% reduction in costs in average hospital. 20% and 20% in a "top" hospital.